



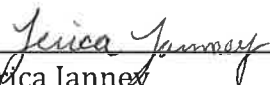
Gender Differences when Coping with Depression

Senior Project

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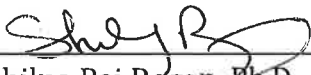
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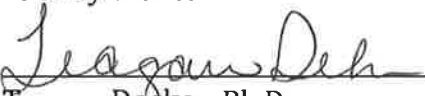
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Abstract

The purpose of this study was to examine the gender differences of coping mechanisms in a depressed sample. The hypothesis was that men use more problem-focused coping mechanisms (i.e. planning, active coping, restraint coping, use of past experiences, and suppression of competing activities), whereas women use more emotion-focused coping mechanisms (i.e. religion, ruminative coping, and avoidance coping) and tend to seek more social support. There were 94 men and women participants aged from 18-22 attending a Southeastern University. They voluntarily completed a questionnaire containing four measures: BEM Sex Role Inventory, Center for Epidemiologic Studies Depression Scale, coping measure, and demographic measure. Overall, there were no significant gender differences in coping mechanisms. The results of this study contrasted with other studies about gender differences of coping mechanisms. Other studies found that men use more problem-focused coping mechanism, whereas females use more emotion-focused coping strategies and seek social support more often. This implies that gender differences have been decreasing over time.

Keywords: Gender Differences, Coping Mechanisms, Depression, College Students

Gender Differences when Coping with Depression

Major depression is a clinically diagnosed psychiatric illness characterized by sadness, loss of interest or pleasure, feelings of guilt, low self-esteem, disrupted sleep or appetite, fatigue or loss of energy, and poor concentration (Agrawal, Jacobson, Gardner, Perscott, & Kendler, 2004; Zhang & Yen, 2015). It is one of the most common mental illnesses (Watts & Markham, 2005). Depression affects 12-25% of adolescents and emerging adults (ages 18-25; Martínez-Hernández, Carceller-Maicas, DiGiacomo, & Ariste, 2016). Depression affects more than 350 million people around the world and is considered one of the significant contributors to diseases (Hanklang, Kaewboonchoo, Morioka, & Plernpit, 2016). It is expected to be the second leading cause of disability by 2020, and the largest contributor to disease burden by 2030 (Zhang & Yen, 2015). Major depression is associated with a high mortality rate, a large portion of which is accounted for by suicide (American Psychiatric Association [APA], 2013).

Coping is a mediator between stress and major depression (Rohde, Lewinsohn, Tilson, & Seeley, 1990). Coping can be defined as the thoughts and acts people use to manage specific stressful situations (problem-focused coping) as well as their emotions (emotion-focused coping; Matud, 2004). Problem-focused coping is a more adaptive coping strategy which includes: active coping, planning, and reflecting on past experience. Emotion-focused coping is a more maladaptive coping strategy that has a vast amount of different types of strategies which include: avoidant coping, distancing, and rumination (Carver et al., 1989; Dunkley et al., 2017; Folkman & Lazarus, 1986; Litman, 2006; McMahon et al., 2013). Coping is a very complex process, evident in the wide range of coping strategies used (Folkman & Lazarus, 1985). People who use more effective coping strategies will experience less disrupted behavior leading to distress (Rohde et al., 1990).

Gender is a factor that affects the input (determining if a situation is stressful) and the output (coping responses and health implications) of the stress process (Matud, 2004). A large amount of research has shown that women or those high in femininity are more likely to use more maladaptive emotion-focused coping strategies; and men or those high in masculinity are more likely to use adaptive problem-focused coping strategies (Dyson & Renk, 2006; Howerton & Van Gundy, 2009; Li et al., 2006; Matud, 2004; Moret-Taytay et al., 2016). However, the literature on gender differences of coping mechanisms has been mixed. The purpose of this paper was to determine which coping mechanisms (problem-focused coping or emotion-focused coping) are used more often by men and women who have depression, and which gender uses more social support.

Symptomatology of Depression

Major Depressive Disorder (MDD) is characterized by high levels of negative affect and low levels of positive affect. MDD features persistent affective disturbances but how these mood states are maintained and changed overtime is not well understood (Dunkley et al., 2017). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has certain criteria that must be met in order to make a diagnosis for MDD. At least five of the nine following symptoms

must be present during a period of at least two consecutive weeks and represent a change from that person's previous functioning: (1) depressive mood (feeling sad, empty, hopeless, discouraged, or "down in the dumps") most of the day (some individuals may exhibit more of an increased irritability rather than sadness), (2) significant loss of interest or pleasure in all (or nearly all) activities (may include sex drive), (3) significant changes in weight (without dieting) or appetite, (4) insomnia (difficulty sleeping) or hypersomnia (excessive sleeping), (5) psychomotor agitation (i.e. inability to sit still, pacing, hand wringing) or retardation (i.e. slowed speech, thinking, and body movements; increased pauses before answering), (6) fatigue or loss of energy, (7) feelings of worthlessness (negative evaluations of one's worth) or guilt (preoccupations or ruminations over minor past events), (8) reduced ability to think, concentrate, or make decisions, (9) recurrent thoughts of death, suicide ideation with or without a specific plan, or a suicide attempt. The previously listed symptoms, except weight change and suicidal ideation, must be present nearly every day in order to be considered present. They must cause clinically significant distress or impairment in important areas of functioning (i.e. social or occupational). Functioning may appear to be normal for some individuals with milder episodes, but there is an increased amount of effort. The episode of depression must not be caused by another mental disorder or the effects of a substance. These three criteria, together, represent a major depressive episode. This episode must not be better explained by another mental illness (i.e. schizophrenia or delusional disorder) and there has never been a manic or hypomanic episode (APA, 2013; Watts & Markham, 2005).

Gender Differences

Gender differences in depression emerge at least by age 12 for diagnosis and at age 12 for symptoms. These differences decline in early adulthood and then remain relatively stable (Salk et al., 2017). Depressive disorders are more common in women: twice as many women experience major depression than men (Salk et al., 2017; Whittle et al., 2015). The lifetime rate for major depressive episodes is 21.3% in women and is 12.7% in men (Zhang & Yen, 2015). Females have a higher persistency and prevalence of depression and significantly more depressive symptoms than males (Hanklang et al., 2016; Li, DiGiuseppe, & Froh, 2006; Moret-Tatay et al., 2016; Zang & Yen, 2015). Women have a higher risk than men for having depression and they have significantly higher levels of depression than men in all countries (Salk et al., 2017; Zhang & Yen, 2015). Throughout all age groups, women report being less happy and having more negative affect than men (Ros et al., 2014).

The literature on masculinity and femininity influences on depression has been mixed. Li et al. (2006) found that there is a negative relationship between masculinity and depression. Dyson and Renk (2006) found that both the masculinity and the femininity of male participants were unrelated to depressive symptomatology. For female participants, masculinity was unrelated to depressive symptomatology, but femininity was significantly related depressive symptomatology. Unlike other studies, they found that the femininity of female participants was negatively related to the level of depressive symptomatology.

Overall, they found that the male and female participants showed similar levels of depressive symptomatology. They inferred that this may be due to sex differences changing over time.

Coping Strategies

Coping is defined as the constant changing of cognitive and behavioral efforts to manage (master, reduce, or tolerate) the external and/or internal demands that have exceeded an individual's capacity or resources (Dyson & Renk, 2006; Folkman & Lazarus, 1985, 1986; Folkman, Lazarus, Gruen, & DeLongis, 1986; Litman, 2006; Matud, 2004; Moret-Tatay et al., 2016; McMahon et al., 2013; Wong et al., 2016). In other words, coping can refer to the thoughts and acts people use to manage specific stressful situations as well as their emotions. There are two major functions of coping: to alter the person-environment stressor (problem-focused coping) and to regulate stressful emotions (emotion-focused coping; Matud, 2004). Coping is a mediator between stress and physical or mental disorder (e.g. depression; Rohde et al., 1990). Depression is associated with feelings of sadness, anxiety, and hostility. A major difference between a depressed and nondepressed person is how they cope with and prevent stress. Depressed people appraise daily events and cope with their demands in different ways than nondepressed people (Folkman & Lazarus, 1986).

Folkman and Lazarus differentiated coping strategies into two major categories: problem-focused coping and emotion-focused coping (Howerton & Van Gundy, 2009; Litman, 2006; Wong et al., 2016). Most stressful situations elicit both types of coping, although the type of situation will determine which coping strategy would be most beneficial (Carver et al., 1989; Wong et al., 2016).

Problem-Focused Coping

Problem-focused coping involves the cognitive and behavioral attempts in changing or eliminating the stressful situation (Matud, 2004). In other words, it is the thoughts or actions used to directly deal with the stressor (Folkman & Lazarus, 1985, 1986; Folkman et al., 1986; Guerreiro, Figueira, Cruz, & Sampaio, 2015; Li et al., 2006; Litman, 2006). This coping style targets the cause of stress in active and practical ways (Carver, Scheier, & Weintraub, 1989; Dyson & Renk, 2006; Moret-Tatay et al., 2016; Wong et al., 2016). The different types of problem-focused coping include: active coping (taking steps to eliminate the problem), planning (thinking about dealing with the problem), seeking social support for instrumental reason (seeking advice, assistance, or information), screening out other activities, suppression of competing activities (focusing only on the problem), restraint coping (forcing oneself to wait before acting), confrontive coping, and reflecting on past experience (Carver et al., 1989; Dunkley et al., 2017; Folkman & Lazarus, 1986; Litman, 2006; McMahon et al., 2013).

Problem-focused coping is a type of engagement coping pattern (dealing with the stressor) that is emotionally positive: it allows for a person to experience positive feelings of efficacy, mastery, and control for many stressors, even in situations that appear to be uncontrollable (Dunkley et al., 2017). It significantly reduces mental health problems by promoting better mental health outcomes and well-being (McMahon et al., 2013; Wong et al., 2016). Problem-focused coping is

associated with reduced levels of depression, lower levels of depressive and anxiety symptoms, and higher self-esteem (Dyson & Renk, 2006; Li et al., 2006; McMahon et al., 2013). People use problem-focused coping more often when the situation is appraised as being controllable and/or changeable and when people feel that something constructive can be done (Carver et al., 1989; Folkman & Lazarus, 1985; Folkman et al., 1986).

Emotion-Focused Coping

Emotion-focused coping are thoughts or actions used for regulation of negative emotions elicited by a stressful situation (Carver et al., 1989; Dyson & Renk, 2006; Guerreiro et al., 2015; Li et al., 2006; Litman, 2006; Matud, 2004; Moret-Tatay et al., 2016; Wong et al., 2016). Different types of emotion-focused coping strategies include: seeking out social support for emotional reasons (getting moral support, sympathy, or understanding), avoidant/escape coping (wishful thinking, tension-reduction (try to make oneself feel better by eating, drinking, smoking, and using drugs or medications), distraction, denial (refusing to believe the problem is real), distancing, self-isolation, and mental or behavioral disengagement), acceptance (learning to accept the problem), positive reappraisal, self-blame, accepting responsibility, rumination (thinking or worrying repeatedly about one's problem), turning to religion (using faith for support), and humor (Carver et al., 1989; Dyson & Renk, 2006; Folkman & Lazarus, 1985, 1986; Folkman et al., 1986; Li et al., 2006; Litman, 2006; Wong et al., 2016).

As opposed to problem-focused coping, emotion-focused coping strategies are predominately used by people who feel the stressor is something that must be endured and when the situation is appraised as being unchangeable (Carver et al., 1989; Folkman & Lazarus, 1985; Howerton & Van Gundy, 2009). It is less effective than problem-focused coping; is regarded as being dysfunctional; is associated with poorer mental health (i.e. higher levels of distress, depressive, and anxiety symptoms, and lower levels of self-esteem); and might result in mental health problems (Li et al., 2006; Matud, 2004; McMahon et al., 2013; Wong et al., 2016). For example, avoidant coping and ruminative coping (two types of emotion-focused coping) are associated with poorer mental health: Avoidant coping is recognized as a maladaptive response that may increase the severity and/or duration of the stressor and exacerbate distress; and ruminative coping is strongly associated with depression (Dunkley et al., 2017; Howerton & Van Gundy, 2009). Emotion-focused coping can also be a form of disengagement coping patterns (escaping the stressor) that is emotionally negative; and it is associated with negative outcomes, maladaptive functioning, and strain for the individual (Dunkley et al., 2017; Dyson & Renk, 2006).

Coping and Depression

Depressed and nondepressed people differ primarily in emotion regulation. Depressed people, use more emotion-focused coping strategies (i.e. distancing, wishful thinking, and avoidance coping), engage in more emotional discharge, and seek more emotional support. There is no difference in the use of problem-focused coping strategies, except the amount of effort used to solve problems. Depressed

people made fewer efforts to solve problems than nondepressed people (Folkman & Lazarus, 1986; Howerton & Van Gundy, 2009).

Gender Differences of Coping Mechanisms

Gender is a factor that affects the input (determining if a situation is stressful) and the output (coping responses and health implications) of the stress process (Matud, 2004). The literature on gender differences of coping mechanisms has been mixed. Many studies have found that women tend to use a greater amount of emotion-focused strategies, whereas men tend to use more problem-focused coping strategies (Dyson & Renk, 2006; Howerton & Van Gundy, 2009; Li et al., 2006; Matud, 2004; Moret-Taytay et al., 2016). Women tend to use more maladaptive emotion-focused coping strategies, such as rumination, seeking help, and crying, than men to regulate their emotions (Howerton & Van Gundy, 2009; Ros et al., 2014). Some studies found no gender differences, but some found that men were more repressive than women (Ros et al., 2014). In one study, females reported using both coping styles more than men (McMahon et al., 2013). Another study found that both men and women utilize many coping strategies, but women tend to use a greater variety of coping mechanisms and are more likely to seek help than men (Howerton & Van Gundy, 2009). Overall, men use more problem-focused coping mechanisms, whereas women use more emotion-focused coping mechanisms and tend to seek more social support.

Masculinity and Femininity

Problem-focused coping strategies are more likely used by men or individuals who rate themselves high in masculine characteristics (e.g., dominant, competitive, aggressive, and independent), whereas emotion-focused coping strategies are more likely used by women or individuals who rate themselves high in feminine characteristics (e.g., affectionate, gentle, loyal, and understanding; Dyson & Renk, 2006; Howerton & Van Gundy, 2009). People who have less masculine traits are at a greater risk for depression, most likely because they will use less problem-focused and distractive coping techniques than those higher in masculinity (Li et al., 2006). Dyson and Renk (2006) found that the masculinity of male participants was related significantly and positively to the use of problem-focused and emotion-focused coping strategies. The femininity of male participants was related significantly and positively to emotion-focused and avoidant coping strategies. Masculinity of female participants was significantly related to the use of problem-focused coping strategies. Femininity of female participants was related significantly and positively to the use of problem-focused and emotion-focused coping strategies. Male and female participants showed similar levels of coping strategies. They inferred that this may be due to sex differences changing over time and/or that all the participants were college students and may be more liberal in what they perceive as appropriate behaviors for men and women (Martínez-Hernández et al., 2016). Masculinity of both male and female participants was positively correlated to problem-focused strategies, whereas femininity of both male and female participants was positively correlated to emotion-focused strategies; but as a whole, males and females had similar levels of coping strategies.

Therefore, gender differences of coping strategies may be due to the differences in gender roles (masculinity versus femininity) and not sex differences (male versus female).

Social Support

Social support acts as a moderator between stress and depressive symptoms. There is a negative relationship between levels of depressive symptoms and perceived social support. Women use their social support networks as a resource to create awareness of their emotional distress (“talking about it”). The awareness of the problem came before self-control. Talking about it with friends allowed them to analyze and problematize what was wrong and then thinking of a solution to the problem. Men use their social support networks to normalize and control their emotional distress (“forgetting about it” by going out, having fun, and partying). Their self-control came before awareness of the problem (Martínez-Hernández et al., 2016).

Men are less likely to seek help (professional or unprofessional), or to delay seeking help, for health-related issues (especially with psychological distress and depression). This appears to be a result of the dominant social expectations around masculinity and the adherence to traditional masculinity norms. Men tend to externalize depression, engaging in numbing behaviors (i.e. alcohol and drug misuse), avoidant behaviors, irritability, and emotional withdrawal. Compared to women, men tend to have lower health literacy and are more likely to self-medicate (e.g. tobacco use; Martínez-Hernández et al., 2016; Whittle et al., 2015).

Explanations for Gender Differences

There are two hypotheses that try to explain the gender differences of different forms of coping: the socialization hypothesis and the role-constraint hypothesis. The socialization hypothesis states that women are more likely to identify with the traditional female gender role (attributed to being dependent, emotionally expressive, and subordination of one’s needs to another’s) and men are more likely to identify with the traditional masculine gender role (attributed to being assertive, autonomous, self-confident, and being goal oriented). Women are socialized into using more passive, emotion-focused coping strategies, whereas men are socialized into using more active, problem-focused coping strategies. The role-constraint hypothesis argues that how a person responds to stress depends upon their social role. If a man and a woman share the same social role, there would be no difference in coping strategies (Matud, 2004).

The coping strategies a person uses is dependent upon the circumstances. For example, during the Gulf War crisis, women used more problem-focused coping strategies and men used more emotion-focused strategies, but after the war, the pattern was reversed. Different coping strategies may be needed because of the different situations men and women are involved in. Women report more stressful events associated with family and health; and men report more stressful events associated with work and finance. They are exposed to different stressors because of the different jobs they have; and women experience sexist stressors such as sexual harassment and assault, rape, and discrimination. Women often have more

chronic stressors, are exposed to more daily stress, and experience stressful events more often than men; they appraise more threatening events as being stressful than men do; and they are affected by the stress of people around them because they are generally more emotionally involved in their social and family networks. Many researchers have found that the gender differences in coping styles has decreased over time and most likely will continue to decrease (Matud, 2004).

Hypothesis

Men use more problem-focused coping mechanisms (i.e. planning, active coping, restraint coping, use of past experiences, and suppression of competing activities), whereas women use more emotion-focused coping mechanisms (i.e. religion, ruminative coping, and avoidance coping) and tend to seek more social support.

Method

Participants

There were 94 individual participants ($N = 94$, males = 25.5%, females = 74.5%) from a University in the Southeast. Ages ranged from 18 to 22 ($M = 18.92$, $SD = .997$). The ethnic background of the sample was as follows: African American (40.4%), Caucasian (26.6%), Bi-racial (12.80), Native American (11.7%), Hispanic/Latino (4.3%), and other (4.3%). The majority of the sample was a traditional college student (93.6%) and lived on-campus (72.3%). The classification of the sample was as follows: Freshman (51.1%), Sophomore (40.4%), Junior (4.3%), and Senior (4.3%). The majority of the students had a single marital status (97.9%). The religious backgrounds of the participants are as follows: Christian (80.9%), non-religious (11.7%), other (4.3%), and Muslim (1.1%).

Measures

Participants completed the following measures in booklet format and took approximately 30 minutes complete.

BEM Sex Role Inventory (BSRI; Bem, 1974). A sixty item measure (20 stereotypically feminine, 20 stereotypically masculine, and 20 neutral questions) that assessed the participants' gender role. Items were measured on a Likert scale that ranges from 1 (never or almost never true) to 7 (always or almost always true). There are four possible categorizations: feminine (scoring above the median for femininity and below the median for masculinity), masculine (scoring above the median for masculinity and below the median for femininity), androgynous (scoring above the mean for femininity and masculinity), and undifferentiated (scoring below the mean for femininity and masculinity). Examples questions included: "I am dominant," "I am affectionate," and "I am friendly."

Coping measure. A thirty-four item measure assessing the types of coping used in a past situation that was very stressful for the participant. Items were measured on a Likert scale ranging from 1 (never) to 4 (always). Examples of questions included: "I used my past experiences to help me with my current situation," "I drank alcohol and/or used drugs to escape the situation," and "I ate more food to comfort me."

Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). A twenty item measure of depression symptoms. Participants were asked to rate how they might have felt or behaved during the past week. Items were measured on a Likert scale ranging from 0 (rarely or none of the time; less than 1 day) to 3 (most or all of the time; 5-7 days). Higher scores indicate the presence of higher levels of depressive symptomatology. Question examples included: "I was happy," "I felt lonely," and "my sleep was restless."

Demographic measure. A nine item measure was used to assess variables such as age, gender, ethnicity, and religious background. The format was composed of mostly multiple choice questions.

Procedure

Participants were recruited via the SONA system which identifies participants with a research number which we were unable to link to their name. The participants met in a group setting (1-25 participants per session) in a designated classroom. They were greeted with a formal, pre-written greeting and an informed consent. The participants completed the survey while the researcher was in the classroom in order to answer any questions the participants had. Participants were debriefed upon completion of the study. Participants received course credit for their participation.

Results

Hypothesis

Problem-focused Coping. Males and females only showed significant differences on how often they use instrumental social support: Females ($M = 3.24$, $SD = .76$) tried to get advice from someone about what to do significantly more often than males ($M = 2.83$, $SD = .81$), $t(92) = -2.21$, $p < .05$. Males ($M = 1.45$, $SD = .65$) and females ($M = 1.55$, $SD = .75$) did not differ significantly on how often they got help from a professional (e.g. counselor) to help them with the situation, $t(92) = -.57$, $p = .56$. Males ($M = 2.66$, $SD = 1.09$) and females ($M = 2.98$, $SD = .92$) did not differ significantly on how often they ask advice from a relative or friend they respected, $t(92) = -1.39$, $p = .16$.

Regarding the use of planning as a coping strategy, males and females did not significantly differ. Males ($M = 2.79$, $SD = .72$) and females ($M = 2.61$, $SD = .76$) did not differ significantly on how often they make a plan of action, $t(92) = .99$, $p = .32$. Males ($M = 3.16$, $SD = .70$) and females ($M = 2.97$, $SD = .72$) did not differ significantly on how often they think about the best way to handle the problem, $t(92) = 1.15$, $p = .25$.

Males and females did not differ significantly on how often they used active coping. Males ($M = 2.66$, $SD = .63$) and females ($M = 2.58$, $SD = .75$) did not differ significantly on how often they tried to strategically remove the stressor from their lives, $t(92) = .47$, $p = .63$. Males ($M = 2.66$, $SD = .91$) and females ($M = 2.67$, $SD = .79$) did not differ significantly on how often they doubled their efforts to make things work because they knew what had to be done, $t(92) = -.02$, $p = .98$.

In regards to how often they used past experiences to help with the current situation, there were no significant differences between males ($M = 3.20$, $SD = .65$)

and females ($M = 3.04$, $SD = .80$), $t(92) = .90$, $p = .36$. Regarding restrain coping, males and females did not differ significantly: Males ($M = 2.41$, $SD = .65$) and females ($M = 2.60$, $SD = .76$) did not differ significantly on how often they restrained themselves from doing anything too quickly, $t(92) = -1.04$, $p = .29$. Males and females did not differ significantly on how often they used suppression of competing activities: Males ($M = 3.04$, $SD = .80$) and females ($M = 2.81$, $SD = .80$) did not differ significantly on how often they concentrated their efforts on doing something about the situation, $t(92) = 1.19$, $p = .23$.

Emotion-focused Coping. Regarding social support for emotional reasons, males ($M = 2.25$, $SD = .94$) and females ($M = 2.48$, $SD = .86$) did not differ significantly on how often they talked to someone about how they were feeling, $t(92) = -1.12$, $p = .26$.

In regards to religion as a coping technique, females ($M = 2.70$, $SD = 1.05$) turned to their religion for guidance significantly more often than males ($M = 2.2$, $SD = .97$), $t(92) = -2.00$, $p < .05$. Females ($M = 3.05$, $SD = 1.04$) also prayed for things to get better significantly more often than males ($M = 2.41$, $SD = 1.13$), $t(92) = -2.52$, $p < .05$.

Males and females did not differ significantly on how often they use ruminative coping: Males ($M = 2.50$, $SD = 1.02$) and females ($M = 2.52$, $SD = .91$) did not differ significantly on how often they dwelled on things that have happened to them in the past, $t(92) = -.12$, $p = .89$. Males ($M = 2.87$, $SD = .89$) and females ($M = 2.91$, $SD = .84$) did not differ significantly on how often they replayed how they acted in past situations, $t(92) = -.19$, $p = .84$.

The results for the use of avoidance coping was mixed. Regarding the use of distractive coping, there were no significant differences between males and females: Males ($M = 3.00$, $SD = .88$) and females ($M = 3.25$, $SD = .84$) did not differ significantly on how often they tried to distract themselves to keep their mind off the issue, $t(92) = -1.27$, $p = .20$. Males and females did not differ significantly on how often they used denial: Males ($M = 2.08$, $SD = .71$) and females ($M = 2.42$, $SD = .95$) did not differ significantly on how often they kept going as if nothing had happened, $t(92) = -1.61$, $p = .10$. In regards to the use of mental disengagement, the results were mixed: Females ($M = 2.72$, $SD = 1.00$) significantly more often slept more than usual when compared to males ($M = 2.00$, $SD = .83$), $t(92) = -3.18$, $p < .05$. Males ($M = 2.25$, $SD = 1.03$) and females ($M = 1.85$, $SD = 1.03$) did not differ significantly on how often they exercised more than usual, $t(92) = 1.60$, $p = .11$. The results for the use of tension-reduction as a coping technique were mixed: females ($M = 2.27$, $SD = .94$) significantly more often ate more food to comfort themselves when compared to males ($M = 1.75$, $SD = .98$), $t(92) = -2.30$, $p < .05$. Males ($M = 1.83$, $SD = .86$) and females ($M = 1.65$, $SD = .89$) did not differ significantly on how often they drank alcohol and/or used drugs to escape the situation, $t(92) = .83$, $p = .40$.

Coping Measure

Problem-focused Coping. The sample had mixed results for how often they used social support for instrumental reasons: they often tried to get advice from someone about what to do ($M = 3.13$, $SD = .79$); they rarely got help a professional (e.g. a counselor) to help them with the situation ($M = 1.53$, $SD = .72$); and they

sometimes asked for advice from a relative or friend they respected ($M = 2.90$, $SD = .97$). The sample had mixed results for how often they used planning: they sometimes made a plan of action ($M = 2.65$, $SD = .755$); and they often thought about the best way to handle the problem ($M = 3.02$, $SD = .71$). The sample sometimes used active coping: they sometimes tried to strategically remove the stressor from their lives ($M = 2.60$, $SD = .72$); and they sometimes doubled efforts to make things work because they knew what had to be done ($M = 2.67$, $SD = .82$). The sample often used past experiences to help with the current situation ($M = 3.08$, $SD = .77$). The sample sometimes used restraint coping: they restrained themselves from doing anything too quickly ($M = 2.55$, $SD = .74$). The sample sometimes used suppression of competing activities: they sometimes concentrated their efforts on doing something about it ($M = 2.87$, $SD = .80$).

Emotion-focused Coping. The sample sometimes used social support for emotional reasons: they sometimes talked to someone about how they were feeling ($M = 2.42$, $SD = .88$). The sample sometimes used religion as a coping mechanism: they sometimes turned to their religion for guidance ($M = 2.57$, $SD = 1.05$); and they sometimes prayed for things to get better ($M = 2.89$, $SD = 1.10$). The sample sometimes used ruminative coping: they sometimes dwelled on things that have happened to them in the past ($M = 2.52$, $SD = .93$); and they sometimes replayed how they acted in past situations ($M = 2.90$, $SD = .85$).

The sample had mixed results for avoidance coping (i.e. distractive coping, denial, mental disengagement, and tension-reduction). The sample often used distractive coping: they tried to distract themselves to keep their mind off the issue ($M = 3.19$, $SD = .85$). The sample would sometimes use denial: they kept going as if nothing had happened ($M = 2.55$, $SD = 2.22$). The sample did not use mental disengagement often: they rarely exercised more than usual ($M = 1.95$, $SD = 1.04$); and they sometimes slept more than usual ($M = 2.54$, $SD = 1.01$). The sample did not use tension-reduction often: they sometimes ate more food to comfort themselves ($M = 2.13$, $SD = .97$); and they rarely drank alcohol and/or used drugs to escape the situation ($M = 1.70$, $SD = .88$).

CES-D

CES-D scores were calculated by summing the total responses of the sample on the depression measure ($N = 94$). The sample's scores ranged from 4 to 51, and reported having low to moderate depressive symptoms ($M = 22.15$, $SD = 11.68$). The majority (66%) of the sample's scores determined clinical significance of depressive symptoms. Total scores for the CES-D were also assessed by gender. Females ($M = 23.53$, $SD = 11.89$) showed a significantly higher level of depressive symptoms than males ($M = 18.13$, $SD = 10.24$), $t(92) = -1.99$, $p < .05$.

BSRI

Masculinity scores were calculated by finding the mean of the masculinity measured questions; and femininity scores were calculated by finding the mean of the femininity measured questions. The sample scored above the median for both femininity ($M = 4.78$, $SD = .62$) and masculinity ($M = 4.89$, $SD = .65$), indicating the sample scored as being androgynous.

Discussion

Hypothesis

The hypothesis that men used more problem-focused coping mechanisms (i.e. planning, active coping, restraint coping, use of past experiences, and suppression of competing activities) than women was not supported. The hypothesis that women used more emotion-focused coping mechanisms (i.e. religion, ruminative coping, and avoidance coping) and social support than men was partially supported. Women used religion as a coping mechanism, certain mental disengagement strategies (i.e. sleeping more than usual), and certain tension-reduction (i.e. eating more than usual) strategies more often than men. Women also used more social support than men when it was for emotional reasons (i.e. emotion-focused coping). The overall results of this study are in contrast to past research which showed that men used more problem-focused coping mechanisms, and women use more emotion-focused coping mechanisms and more social support (Dyson & Renk, 2006; Howerton & Van Gundy, 2009; Li et al., 2006; Matud, 2004; Moret-Taytay et al., 2016). The information below is a further explanation of the findings.

Coping Measure

Male and female participants showed similar levels of coping strategies. Overall, the sample did not use coping mechanisms often except for a few problem-focused coping mechanisms and one emotion-focused coping mechanism. The problem-focused mechanisms that were used often were: they often tried to get advice from someone about what to do (a form of instrumental social support), they often thought about the best way to handle the problem (a form of planning), and they often used past experiences to help with the current situation. The emotion-focused coping mechanism that was used often was distractive coping (a form of avoidance coping).

The lack of coping strategies used was surprising because college students in past research used both problem-focused and emotion-focused coping mechanisms (Dyson & Renk, 2006; Folkman & Lazarus, 1985). Due to the deficiency in the use of coping mechanisms across the entire sample, it was not surprising that males and females did not differ significantly with problem-focused and emotion focused coping mechanisms for this study. The lack of significant gender differences may be due to gender differences decreasing over time and/or that all the participants were college students and may be more liberal in what they perceive as appropriate behaviors for men and women (Dyson & Renk, 2006; Martínez-Hernández et al., 2016; Matud, 2004).

CES-D

Majority of the sample's scores determined clinical significance of depressive symptoms. The sample scores showed low to moderate levels of depressive symptoms. Females reported more depressive symptoms than males. This is in agreement with current research showing that females have significantly more depressive symptoms than males (Hanklang et al., 2016; Li, DiGiuseppe, & Froh,

2006; Moret-Tatay et al., 2016; Zang & Yen, 2015). The levels of depressive symptomatology were not surprising seeing that the majority of the sample was a freshman, and freshmen in college, or those adjusting to university life, exhibit higher levels of depression (Dyson & Renk, 2006).

The lack of problem-focused coping mechanisms used can be explained by the higher levels of depressive symptomatology; depressed people tend to use fewer efforts to solve problems. It was surprising at the lack of emotion-focused coping mechanisms due to research showing depressed people using more emotion-focused coping mechanisms (i.e. avoidance, distancing, and wishful-thinking) and social support than non-depressed people (Folkman & Lazarus, 1986; Howerton & Van Gundy, 2009).

BSRI

The sample scored as being androgynous, they show a combination of masculine and feminine characteristics. Many studies have shown that problem-focused coping strategies are more likely used by men or individuals who rate themselves high in masculine characteristics (e.g., dominant, competitive, aggressive, and independent), whereas emotion-focused coping strategies are more likely used by women or individuals who rate themselves high in feminine characteristics (e.g., affectionate, gentle, loyal, and understanding; Dyson & Renk, 2006; Howerton & Van Gundy, 2009). The role-constraint hypothesis argues that how a person responds to stress depends upon their social role. If a man and a woman share the same social role, there would be no difference in coping strategies (Matud, 2004). It was not surprising that the hypothesis that men use more problem-focused coping mechanisms, whereas women use more emotion-focused coping mechanisms and seek more social support was not supported due to the fact that the sample was androgynous (they had high levels of masculinity and femininity). This is in agreement to the role constraint hypothesis in that there were no significant gender differences of coping mechanisms because the sample shared the same social role (they were androgynous).

Implications

Overall, this study found that there was no significant difference in the amount of problem-focused coping strategies, emotion-focused coping strategies, and social support used between genders. These results oppose many of the findings of past research which have found out that on average, men are more likely to use problem-focused coping strategies, whereas women are more likely to use emotion-focused coping strategies and social support. This supports the notion that there may be a decline in gender differences and that college students are generally more liberal in thinking with regards to appropriate social roles.

Limitations and Future Research Directions

The main limitation is the ratio of male to female participants because the main purpose of this study was to evaluate the gender differences of coping mechanisms. There was an unequal gender balance because majority of the participants in the sample were female. A second limitation is that participants

completed the survey quickly and may not have fully read and understood the questions that they were answering, thus increasing the possibility of inaccurate data. This study also has its limitations with regards to external validity because there were only 94 participants (all of which were in an introductory psychology course at the same university); the majority of the participants were female, single, a freshman, and African American; and had a religious background of Christianity. A large portion of the literature is focused on gender differences of coping mechanisms, but future research needs to be focused on gender role differences (i.e. masculinity vs. femininity vs. androgyny vs. undifferentiated) of coping mechanisms.

Conclusion

The purpose of this paper was to determine which coping mechanisms (problem-focused coping or emotion-focused coping) are used more often by men and women who have depression, and which gender uses more social support. The overall results of this study indicate that there are not significant differences between males and females and their coping mechanisms. This may be due to majority of the participants being female, the overall sample being androgynous, and the lack of the use of coping mechanisms. This study opposes the majority of research on this topic which states that problem-focused coping strategies are more likely used by men, whereas emotion-focused coping strategies and social support are more likely used by women.

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